

## CERTIFICATION OF VITAL RECORD

COUNTY OF LOS ANGELES  
DEPARTMENT OF HEALTH SERVICES

## CERTIFICATE OF DEATH

STATE OF CALIFORNIA  
USE BLACK INK ONLY / NO ERASURES, WRITEOUTS OR ALTERATIONS

VS-11 (REV 2/05)

3 2006 19 052635

LOCAL REGISTRATION NUMBER

STATES FILE NUMBER		2. MIDDLE		3. LAST (Family)		4. DATE OF BIRTH mm/dd/yy				5. AGE Yrs.		6. UNDER ONE YEAR Months Days Hours Minutes		7. DATE OF DEATH mm/dd/yy		8. HOUR (24 Hours)			
1. NAME OF DECEDENT - FIRST (Given) <b>Rodney</b>		Tutuila		<b>Asuega</b>		[REDACTED]				37				12/27/2006		1350			
AGL ALSO KNOWN AS - Include full AKA (First, Middle, Last)																			
DECEDENT'S PERSONAL DATA		9. BIRTH STATE/FOREIGN COUNTRY <b>California</b>		10. SOCIAL SECURITY NUMBER [REDACTED]		11. EVER IN U.S. ARMED FORCES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNK		12. MARITAL STATUS/SPC (At Time of Death) <b>Never Married</b>		13. EDUCATION - Highest Level/Degree HS Graduate		14. WAS DECEDENT HISPANIC/LATIN/SPANISH? (If yes, see worksheet on back) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		15. DECEASED'S RACE - Up to 3 races may be listed (see worksheet on back) <b>Samoa</b>		16. KIND OF BUSINESS OR INDUSTRY (e.g., grocery store, road construction, employment agency, etc.) <b>Producer</b>		17. YEARS IN OCCUPATION <b>Music</b>	
USUAL RESIDENCE		20. DECEASED'S RESIDENCE (Street and number, or location) [REDACTED]		21. CITY <b>Los Angeles</b>		22. COUNTY/PROVINCE <b>Los Angeles</b>		23. ZIP CODE <b>90020</b>		24. YEAR IN COUNTY <b>30</b>		25. STATE/FOREIGN COUNTRY <b>CA</b>		26. INFORMANT'S NAME, RELATIONSHIP <b>Vera Hisatake - Mother</b>		27. INFORMANT'S MAILING ADDRESS (Street and number, or route numbers, city or town, state and zip) <b>San Francisco, CA 94134</b>			
INFORMANT		28. NAME OF SURVIVING SPOUSE/SPCP-FIRST [REDACTED]		29. MIDDLE		30. LAST BIRTH NAME [REDACTED]		31. NAME OF FATHER/PARENT-FIRST <b>Hale</b>		32. MIDDLE		33. LAST <b>Hisatake</b>		34. BIRTH STATE <b>Pago Pago</b>					
PARENT INFORMATION		35. NAME OF MOTHER/PARENT-FIRST <b>Falemalama</b>		36. MIDDLE		37. LAST BIRTH NAME <b>Hisatake</b>		38. BIRTH STATE <b>Pago Pago</b>											
FUNERAL DIRECTOR/LOCAL REGISTRAR		39. DISPOSITION DATE mm/dd/yy <b>01/06/2007</b>		40. PLACE OF FINAL DISPOSITION <b>Cypress Lawn Memorial Park, 1370 El Camino, Colma, CA 94014</b>		41. TYPE OF DISPOSITION <b>Burial</b>		42. SIGNATURE OF EMBALMER <b>Not Embalmed</b>		43. LICENSE NUMBER [REDACTED]		44. NAME OF FUNERAL ESTABLISHMENT <b>Universal Chung Wah Funeral Home</b>		45. DATE mm/dd/yy <b>12/29/2006</b>					
PLACE OF DEATH		46. PLACE OF DEATH <b>Residence</b>		47. HOSPITAL SPECIFIC ONE <b>EVOP DCA</b>		48. IF OTHER THAN HOSPITAL, SPECIFY ONE <b>Hospital</b>		49. IF FEMALE, PREGNANT IN LAST YEAR <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNK											
CAUSE OF DEATH		50. COUNTY <b>Los Angeles</b>		51. FACILITY ADDRESS OR LOCATION WHERE FOUND (Street and number, or location) [REDACTED]		52. CITY <b>Los Angeles</b>		53. DEATH REPORTED TO CORONER <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO											
IMMEDIATE CAUSE (A) Final disease or condition resulting in death (B) Secondary, 2nd conditions, if any, leading to cause on Line A (C) Underlying condition (disease or injury that initiated the events resulting in death) LAST		54. SIGNATURE AND TITLE OF CERTIFIED <b>Jonathan E Fielding MD</b>		55. TIME INTERVAL BETWEEN ONSET AND DEATH <b>04 MINS.</b>		56. DEATH REPORTED TO CORONER <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO													
Sudden death, 3rd conditions, if any, leading to cause on Line A (D) Initiating event(s) which initiated the events resulting in death LAST		57. ATTENDING PHYSICIAN'S NAME, MAILING ADDRESS, ZIP CODE <b>David Masiello, M.D. 1200 N. State St., Los Angeles, CA 90033</b>		58. DATE OF INJURY mm/dd/yy <b>06/03/2005</b>		59. BIOCPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO													
101. PLACE OF DEATH Residence		60. HOSPITAL SPECIFIC ONE EVOP DCA		61. IF OTHER THAN HOSPITAL, SPECIFY ONE Hospital		62. IF FEMALE, PREGNANT IN LAST YEAR <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNK													
104. COUNTY <b>Los Angeles</b>		63. FACILITY ADDRESS OR LOCATION WHERE FOUND (Street and number, or location) [REDACTED]		64. CITY <b>Los Angeles</b>		65. DEATH REPORTED TO CORONER <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO													
107. CAUSE OF DEATH Enter the chief underlying cause and all complications that directly caused death. DO NOT enter intermediate events such as cardiac arrest, respiratory arrest, shock, etc. Do not abbreviate, however, the acronym, DO NOT ABBREVIATE.		66. DATE OF INJURY mm/dd/yy <b>03/04/2006</b>		67. ATTENDING PHYSICIAN'S NAME, MAILING ADDRESS, ZIP CODE <b>Surgery 08/01/2006</b>		68. DATE OF INJURY mm/dd/yy <b>08/01/2006</b>													
108. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RESULTING IN THE UNDERLYING CAUSE GIVEN IN 107 None		69. DATE OF INJURY mm/dd/yy <b>06/03/2005</b>		70. ATTENDING PHYSICIAN'S NAME, MAILING ADDRESS, ZIP CODE <b>MD</b>		71. DATE OF INJURY mm/dd/yy <b>12/28/2006</b>													
113. WAS OPERATION PERFORMED FOR ANY CONDITION IN ITEM 107 OR 112? If yes, list type of operation and date <b>Colectomy 06/03/2005, Bowel Tumor Removed 03/04/2006, Surgery 08/01/2006</b>		72. DATE OF INJURY mm/dd/yy <b>12/19/2006</b>		73. ATTENDING PHYSICIAN'S NAME, MAILING ADDRESS, ZIP CODE <b>David Masiello, M.D. 1200 N. State St., Los Angeles, CA 90033</b>		74. DATE OF INJURY mm/dd/yy <b>12/28/2006</b>													
114. I CERTIFY THAT TO THE BEST OF MY KNOWLEDGE DEATH OCCURRED AT THE HOUR, DATE, AND PLACE STATED FROM THE CAUSES STATED. Decedent Attended Since <b>Decedent Last Seen Alive</b>		75. SIGNATURE AND TITLE OF CERTIFIED <b>MD</b>		76. LICENSE NUMBER <b>A946850</b>		77. DATE mm/dd/yy <b>12/28/2006</b>													
115. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Homicide <input type="checkbox"/> Suicide <input type="checkbox"/> Pending <input type="checkbox"/> Investigation <input type="checkbox"/> Could not be determined		78. INJURED AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNK		79. INJURY DATE mm/dd/yy <b>12/28/2006</b>		80. HOUR (24 Hours) <b>122</b>													
116. PLACE OF INJURY (e.g., home, construction site, wooded area, etc.) <b>[REDACTED]</b>		81. DATE mm/dd/yy <b>[REDACTED]</b>		82. TYPE NAME, TITLE OF CORONER/DEPUTY CORONER <b>[REDACTED]</b>		83. CENSUS TRACT <b>* H00559990*</b>													
117. DESCRIBE HOW INJURY OCCURRED (Events which resulted in injury) <b>[REDACTED]</b>		84. DATE mm/dd/yy <b>[REDACTED]</b>		85. DATE mm/dd/yy <b>[REDACTED]</b>		86. DATE mm/dd/yy <b>[REDACTED]</b>													
118. LOCATION OF INJURY (Street and number, or location, and city, and zip) <b>[REDACTED]</b>		87. DATE mm/dd/yy <b>[REDACTED]</b>		88. DATE mm/dd/yy <b>[REDACTED]</b>		89. DATE mm/dd/yy <b>[REDACTED]</b>													
119. SIGNATURE OF CORONER / DEPUTY CORONER <b>[REDACTED]</b>		90. DATE mm/dd/yy <b>[REDACTED]</b>		91. DATE mm/dd/yy <b>[REDACTED]</b>		92. DATE mm/dd/yy <b>[REDACTED]</b>													
STATE REGISTRAR 0195		A B C D E				FAX AUTH.#													

This is a true certified copy of the record filed in the County of Los Angeles Department of Health Services if it bears the Registrar's signature in purple ink.

*Jonathan E Fielding MD*  
VC DATE ISSUED JAN - 2 2007

Director of Health Services and Registrar

This copy not valid unless prepared on engraved border displaying seal and signature of Registrar.